PRINTED: 05/23/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7105	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	05/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE CENTER	444 ONE ELEVEN PLACE COOKEVILLE, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 831	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the physical plant and overall environment of the facility. The finding included: Observation on 5/23/16 at 8:47 AM, revealed the wall behind bed A inside of room 510 was damaged. This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 5/23/16.	N 831	N831 1 The Maintenance Director fixed the wall behind 510A on 5-23-2016. 2 The Maintenance Director did a walk through of the facility to make sure all patient rooms was not damaged on 5-24-2016 and all rooms are in compliance. 3 The Maintenance Director will do weekly checks to monitor the walls to make sure they are compliant. The Maintenance Director was in-serviced on this 5-24-16 by the Administrator. 4 The Maintenance Director/Administrator will do monthly checks for 3 months to ensure the deficient practice does not recur in in resident rooms. Findings will be reported to the QA Leadership team for review and resolution.	5-24-15

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LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/10/16